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REPORT OF A CASE OF TYPHOID FEVER COMPLICATED BY EXTRAUTERINE PREGNANCY.

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I DESIRE to place on record the following case, because of the rare, if not unique, combination of typhoid fever and extrauterine pregnancy.

A woman, about thirty-eight years of age, entered the Cook County Hospital, January 25, 1896, with many of the initial symptoms of typhoid fever—headaches, chilliness, anorexia, malaise, fever for several days, etc. No splenic tumor or rose-spots could, however, be made out at this time, and a diagnosis of typhoid was, therefore, reserved. This reservation was also made, because of the suspicion of a puerperal or *post-partum* septicemia. The patient told us that a few weeks before, being, as she then supposed, three months pregnant, she had taken medicine to bring on an abortion and had, as she believed, accomplished the object. For there had been a discharge of blood with some other material, that she described very indefinitely, but which she thought was the fetus. This continued for nearly three weeks, and then she suffered from the loss of appetite, the headache, the chilliness, etc., that finally induced her to come to the hospital. A fact that she reported, and which, in the light of later revelations was very significant, but to which not enough importance was attached in the making of the diagnosis, was that about this time, *i.e.*, the time of the supposed miscarriage, she had suffered severe abdominal

pain, nausea, and had an attack of fainting, with some form of convulsion.

The examination gave the ordinary findings in a fever patient. In addition, there was plainly made out what was believed to be an enlarged uterus, presumably four months advanced in pregnancy. The question of its containing a live or dead fetus, secundines, or a fibroid, was discussed as well as the possibility of its being the source of infection. The absence of odor, discharge, or evidence of local uterine or peritoneal inflammation, with the many indications of typhoid, led to an expectant and non-interfering policy. This was rewarded in a few days by the appearance of rose-spots, and by such enlargement of the spleen as to make this organ plainly palpable. The diagnosis was further confirmed by an intestinal hemorrhage that proved fatal. The urine had shown on all examinations an abundance of albumin with numerous casts.

The autopsy (Drs. Hektoen and Tice) revealed healed apical tuberculosis, old pleuritis, pericarditis, endarteritis, chronic nephritis, and a ureteral anomaly. The findings, to which I call attention, were:

1. *Typhoid fever.*—Typical typhoid ulcers in ileum and colon; enlarged mesenteric glands; splenic tumor; typhoid bacilli in spleen, kidney, and heart's blood.

2. *Extrauterine pregnancy.*—The uterus was slightly increased in size and pushed to the left. Back of the uterus, occupying the middle of the pelvis and rising above its brim, was a globular mass containing a mummified fetus, placental tissue, and an old blood-clot. This mass was bound to the surrounding intestines by firm adhesions. The right tube could be traced for but half the length of the left. Apparently there had been primary right tubal pregnancy, with rupture at the time of the pain and syncope.

I have been unable to find other records of this unusual accidental complication of typhoid fever, and report the

case, therefore, because of its rarity. It also teaches the lesson that it is not always wise to resort to operations—even exploratory operations—until the diagnosis is reasonably clear. It is often good practice to wait for hours or days before deciding as to the nature of an illness or the method of treatment proper to be employed. Had operative interference been resorted to, in this case, for the removal of a possible uterine source of infection, death would probably have resulted earlier than it did, and from the effects of the operation. The patient with typhoid and chronic nephritis would have been a poor subject for the surgeon. Had we been more skillful in recognizing the extrauterine pregnancy, the temptation would have been very strong to have looked upon the case as one of infected gestational sac, and clearly suitable for immediate operation. Fortunately, we temporized, and the death cannot be attributed to too zealous or unskilled treatment, but solely to acute anemia following intestinal hemorrhage.